Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

OSF OCCUPATIONAL HEALTH AT RANDOLPH
100 N.E. RANDOLPH
PEORIA, IL 61606

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-10-2503-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Charles Hill, work comp adjustor for Texas Mutual on 12/08, all referrals and physical therapy visits can be done anywhere as he was out of the network area and the same rules did not apply when out of network. It was assumed that this meant the physical therapy would be authorized if necessary. We were not aware that all physical therapy requests needed to go through a utilization review by Texas Mutual or we would have sent that request. "

Amount in Dispute: $6,175.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided physical therapy to the claimant from 4/6/2009 to 10/6/2009. Upon receipt of the billing Texas Mutual audit staff reviewed the claimant file for preauthorization of this and found none. None of the waivers for preauthorization apply to the case here. Absent such Texas Mutual believes no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2009 Through October 6, 2009	97001, 97110, 97140, 97530, 97014, 97032	$6,175.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600 sets out the procedures for Prospective and Concurrent Review of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 26, 2009
- 18- Duplicate claim/service.
- 459-This provider has already billed and been reimbursed for an initial office visit.

Explanation of benefits dated August 12, 2009
- W1-Workers' Compensation State Fee Schedule Adjustment
- W4- No additional reimbursement allowed after review of appeal/reconsideration.
- 370-This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 891-The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated September 4, 2009
- Allowance was made in conjunction with Rule 134.403(H)
- W1-Workers' Compensation State Fee Schedule Adjustment.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 18-Duplicate Claim/Service.
- 494-Hospital outpatient allowance was calculated to Medicare's methodology plus a markup per the Texas Fee Schedule.
- 878-Duplicate Appeal. Request Medical Dispute Resolution through DWC for continued disagreement of original appeal decision.
- 891-The Insurance company is reducing or denying payment after reconsideration.
- 197-Precertification/Authorization/notification absent.
- 930-Pre-Authorization required, reimbursement denied.

Explanation of benefits dated June 29, 2009
- 197-Precertification/Authorization/notification absent.
- 930-Pre-Authorization required, reimbursement denied.

Explanation of benefits dated September 4, 2009
- W4-No additional reimbursement allowed after review of appeal/reconsideration
- 197- Precertification/Authorization/notification absent.
- 891- Insurance company is reducing or denying payment after reconsideration.
- 930- Pre-Authorization required, reimbursement denied.

Explanation of benefits dated September 10, 2009
- 29-The time limit for filing has expired.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.

Explanation of benefits dated September 16, 2009
- 197- Precertification/Authorization/notification absent.
- 29- The time limit for filing has expired.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
- 930- Pre-Authorization required, reimbursement denied.

Explanation of benefits dated September 30, 2009
- 29- The time limit for filing has expired.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
- 18-Duplicate Claim/Service.
- 224-Duplicate Charge

Explanation of benefits dated November 9, 2009
- 197- Precertification/Authorization/notification absent.
- 29- The time limit for filing has expired.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
- 930- Pre-Authorization required, reimbursement denied.

Explanation of benefits dated December 14, 2009
- 197- Precertification/Authorization/notification absent.
- 29- The time limit for filing has expired.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
- 930- Pre-Authorization required, reimbursement denied.

Explanation of benefits dated December 16, 2009

- W1-Workers' Compensation State Fee Schedule Adjustment.
- 197- Precertification/Authorization/notification absent.
- 29- The time limit for filing has expired.
- 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 731-134.801 &133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.
- 732-Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or Modifier billed incorrectly.
- 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- 930-Pre-Authorization required, reimbursement denied.

Explanation of benefits dated December 31, 2009

- 930- Denied in accordance with 134.600(P)(12) as the treatment/service is in excess of the Division's Treatment Guidelines as outlined in the disability management rules effective 5/1/07. Please refer to the Disability Management Rules Chapter 137 on the Division's website.
- 197- Precertification/Authorization/notification absent.
- 930- Pre-Authorization required, reimbursement denied.

Issues

1. Did the Requestor obtain preauthorization for physical therapy services "prior" to rendering services in accordance with 28 Texas Administrative Code §134.600(p)? ?
2. Is the Requestor entitled to additional reimbursement for CPT code 97001 in accordance with 28 Texas Administrative Code §134.203(c)1?
3. Is the Requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600(p)(5) states in pertinent part, "Non-emergency health care requiring preauthorization includes: physical and occupation therapy services…" Review of the submitted documentation by the Requestor finds a position statement dated January 5, 2010. In this position statement the Requestor states, "On 8/12/09 we were notified by Texas Mutual that the physical therapy visits were not covered because there had been no request for preauthorization. A pre-authorization form with medical notes from Dr. Conway and Dr. Burke was sent immediately to Texas Mutual but it was not accepted since it had not been completed prior to the therapy visits."
2. Per 28 Texas Administrative Code §134.600(c)(1)(B), "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care". Therefore, the Division concludes that the Requestor has forfeited the right to reimbursement due to providing services to injured employee "prior" to obtaining preauthorization from the Respondent.
3. According to the Requestor's Table of Disputed Service the Respondent made a payment in the amount of $100.29 for CPT code 97001. Per Rule 134.203(c)1, the MAR (Maximum Allowable Reimbursement)for CPT code 97001 is $100.29. Therefore, the Division concludes that the no additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.